RESET FORM

ACCELERATED BENEFIT CLAIM

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the Voya family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. So., Minneapolis, MN 55401

The Group, Insured, Dependent Information and Certification must be completed by the employer. The Insured is responsible for completion of the remaining sections of the form. The separate Attending Physician's Statement must be completed by the Insured's attending physician. Return the completed forms, along with a copy of the Insured's enrollment form(s), to the above address.

CLAIM CHECKLIST

☐ Is the Employer Certification complete and signed?
☐ Is the Insured's Statement complete and signed?
☐ Is the enrollment documentation attached?
☐ Has the Attending Physician's Statement been completed and signed by the Insured's Attending Physician?

GROUP POLICYHOLDER INFORMATION

Group Name _____

Group Policy Number _____ Account Number _____

INSURED INFORMATION

Name _____

Birth Date _____ SSN _____

Other Names the Insured May Have Been Known By *(maiden name, hyphenated, nickname, derivative of first or middle name, or alias):*

_____

Address _____

City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Employee's Employment Start Date _____ Employee's Date Last Actively at Work _____

Employee's Job Title _____

Employee's Salary $ _____ per: ☐ hour ☐ week ☐ month ☐ year Last Salary Change Date _____

Employment Status: ☐ Full Time ☐ Part Time Average hours per week _____

Employee Status: ☐ Active ☐ Retired ☐ Disability Waiver of Premium ☐ FMLA *(include FMLA documentation)* ☐ Union ☐ Non Union

Have premiums been paid to the current date? . . . . . ☐ Yes ☐ No

If "No," to what date have premiums been paid? _____

COVERAGE INFORMATION

Basic Life $ _____ Effective Date _____

Supplemental Life $ _____ Effective Date _____

Optional Life $ _____ Effective Date _____

Other $ _____ Effective Date _____

SEE FRAUD WARNINGS ON PAGE 4.

Insured Name _____ SSN _____ Group Policy Number _____

DEPENDENT INFORMATION

If claim is for accelerated benefits on a dependent spouse, give the following information *(list amount on previous page.)*

Relationship to the Employee: ☐ Spouse ☐ Domestic Partner/Civil Union Date Insured _____

Name *(Please print.)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____

City _____ State _____ ZIP _____

EMPLOYER CERTIFICATION *(The undersigned certifies that the above statements as to the insured are correct as reported on its records.)*

Employer Name _____

Employer Address _____

City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Title _____ Phone (_____)_____

Email _____

INSURED STATEMENT *(Please read and sign below also.)*

Date Employee Last Worked Preceding Claim *(month, day, year)* _____

Describe Condition or Illness _____

ATTENDING PHYSICIAN(S) *(List your primary care physicians.)*

Physician Name _____ Date _____

Physician Address _____ Phone (_____)_____

City _____ State _____ ZIP _____

Cause _____

Physician Name _____ Date _____

Physician Address _____ Phone (_____)_____

City _____ State _____ ZIP _____

Cause _____

Physician Name _____ Date _____

Physician Address _____ Phone (_____)_____

City _____ State _____ ZIP _____

Cause _____

Insured Name _____ SSN _____ Group Policy Number _____

US TAXPAYER CERTIFICATIONS

Under penalties of perjury, I certify that:
1. The Taxpayer Identification Number that appears on this form is correct,
2. I am not subject to backup withholding due to failure to report interest and dividend income[1], and
3. I am a U.S. person.

[1]If you are subject to back-up withholding, you must strike through statement number 2.

NON-RESIDENT ALIEN STATUS
If you are a Non-Resident Alien, please check the box below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

ACKNOWLEDGEMENT AND AUTHORIZATION

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc. (MIB) or employer to give ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York ("the Company") or its agents, employees and authorized representatives acting on its behalf, ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information as they apply to me.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

NOTE: Receipt of accelerated benefits may be taxable. Assistance should be sought from a personal tax advisor. Receipt of these accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Receipt of these accelerated benefits may adversely affect the recipient's eligibility for future increases in life insurance coverage. Please refer to your certificate booklet for more information.

If accelerated benefits are paid, continued premium payments must be made, unless waived under the provisions of the policy, to keep life insurance coverage in force.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Insured Signature _____ Date _____

Phone (_____)_____ Email _____

Insured Name _____ SSN _____ Group Policy Number _____

RELEASE

Release By Irrevocable Beneficiary or Assignee, or By Spouse in a Community Property State

If there is an irrevocable beneficiary or assignee, that person must sign this section and have it notarized. If you are married and live in a community property state, your spouse must sign this section and have it notarized.

The undersigned acknowledges and consents to this accelerated benefit claim; that if approved, payment of the accelerated benefit shall be made to the insured or his/her legal representative; and in consideration of such payment the undersigned agrees that the liability of the insurance company under the policy shall be discharged by the amount of the accelerated benefit paid.

Irrevocable Beneficiary or Assignee Signature _____ Date _____

Spouse Signature *(in Community Property State)* _____ Date _____

NOTARY SECTION *(required with the release by irrevocable beneficiary or assignee or spouse)*

State of _____

County of _____ ss.

On this _____ day of _____, 20 _____ before me personally appeared _____ to me known to be the same person who executed the above instrument and acknowledged that he/she executed the same as his/her free act and deed.

My commission expires _____ Notary Public _____

FRAUD WARNINGS

Alabama, Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.